

# Attending Physician's Statement Major Disease/Critical Illness Bacterial Meningitis

**Patient's Name**

\_\_\_\_\_

**Attending Physician's Name**

**Address**

\_\_\_\_\_

\_\_\_\_\_

**This section must be completed by a qualified and registered physician at the expense of the claimant.**

The above name is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with **BACTERIAL MENINGITIS**. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

**A. GENERAL INFO MATION**

1. Are you the patient's usual medical doctor?  Yes  No

If yes, over what period do your records extend to?

Start date    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                  dd       mm       yyyy

End date       \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
                  dd       mm       yyyy

2. When did the patient first consult you for this condition?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
dd       mm       yyyy

3. Please state symptoms presented and date symptoms first appeared.

Symptoms Presented at First Consultation	Date Symptoms First Started (DD/MM/YYYY)

What / Who is the source of this information? \_\_\_\_\_

4. In your opinion what were the likely durations of the patient's symptoms? Please provide reasons.

\_\_\_\_\_  
\_\_\_\_\_

5. Did the patient consult any other doctors for these symptoms before he/she consulted you?  Yes  No

If yes, please provide details below.

Name of Doctor	Name of Clinic/ Hospital and Address



8. Was there inflammation of the membranes of the brain or spinal cord?  Yes  No

9. (a) How long has the patient's functional neurological impairment lasted since the initial episode? Please provide duration in hours / days / weeks.

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(b) Please provide description of the functional neurological impairment.

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(c) Is the functional neurological impairment permanent?  Yes  No

10. Please provide details of all investigations/test performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.

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11. Are the investigation findings consistent with the diagnosis of Bacterial Meningitis?  Yes  No  
If yes, please give details.

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12. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

Name of Doctor	Name of Clinic/ Hospital and Address

### C. MEDICAL HISTORY

13. Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischemic attack, angina and other cardiovascular diseases)?  Yes  No

If yes, please provide details.

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14. Is there anything in the patient's medical history which would have increased the risk of Bacterial Meningitis?

Yes  No

If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor. Please state source of information. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. Please give details of the patient's family history which would have increased the risk of having Bacterial Meningitis (including the relationship, nature of illness, date of diagnosis. Please state source of information. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

16. Does the patient have or ever had any other significant health condition(s)?  Yes  No

If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

\_\_\_\_\_  
\_\_\_\_\_

**D. ADDITIONAL INFORMATION**

17. Please provide us with any other additional information that will enable the Company to assess this claim.

\_\_\_\_\_  
\_\_\_\_\_

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**I hereby certify that the above statements are true and complete to the best of my knowledge and belief.**

\_\_\_\_\_  
**Signature Over Printed Name of Physician**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Qualification**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**PRC Number / PTR Number**

\_\_\_\_\_  
**Telephone Number (s)**

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**To the Attending Physician :** You may use additional sheets if more space is needed for the above information requested. If you wish, please send the form directly to Claims & Settlement Department with office address shown below.